ATI Proctored Exam Maternal Newborn CMS 2023 GRADED A LATEST VERSION

A nurse is providing discharge teaching to a client following tubal ligation (occlusion). Which of the following statement by the client indicates an understanding of the teaching?

A. "premenstrual tension will no longer be present."
B. "Ovulation will remain the same."
C. "Hormone replacements will be needed following this procedure."
D. "My monthly menstrual period will be shorter." - CORRECTANSWER
B. "Ovulation will remain the same."

Ovulation (egg release from the ovaries) will remain the same. Tubal ligation also known as having your tubes tied or tubal sterilization is a type of permanent birth control. During tubal ligation, the fallopian tubes are cut, tied or blocked to permanently prevent pregnancy. Tubal ligation prevents an egg from traveling from the ovaries through the fallopian tubes and blocks sperm from traveling up the fallopian tubes to the egg. The procedure doesn't affect your menstrual cycle it just prevents fertilization.

A nurse is assessing a newborn following forceps-assisted birth. Which of the following clinical manifestations should the nurse identify as a complication of the birth method?

A. Hypoglycemia
B. Polycythemia
C. Facial Palsy
D. Bronchopulmonary dysplasia - CORRECTANSWER C. Facial Palsy

Difficult delivery, with or without the use of an instrument called forceps, may lead to facial palsy. Facial paralysis 15 minutes after forceps birth or absence of movement on affected side is especially noticeable when infant cries.

A nurse is providing teaching about terbutaline to a client who is experiencing preterm labor. Which of the following statements by the client indicates understanding of the teaching?

A. "This medication could cause me to experience heart palpitations."
B. "This medication could cause me to experience blurred vision."
C. "This medication could cause me to experience ringing in my ears."
D. "This medication could cause me to experience frequent urination." - CORRECTANSWER A. "This medication could cause me to experience heart palpitations."

Beta-adrenergic agents such as terbutaline (Brethine) are associated with various side effects, including tachycardia, irregular pulse, myocardial ischemia, and pulmonary edema. Therefore, these medications should not be used in women with known or suspected heart disease

A nurse is caring for a client who is in labor and requests nonpharmacological pain management. Which of the following nursing actions promotes client comfort?

A. Assisting the client into squatting position
B. Having the client lie in a supine position
C. Applying fundal pressure during contractions
D. Encouraging the client to void every 6 hrs. - CORRECTANSWER C. Applying fundal pressure during contractions

Applying fundal pressure by pushing on the mother's abdomen in the direction of the birth canal is often used to assist spontaneous vaginal birth, shorten the length of the second stage and reduce the need for instrumental birth (forceps- or vacuum-assisted) or caesarean section.

A nurse caring for a client who is at 20 weeks of gestation and has trichomoniasis. Which of the following findings should the nurse expect?

A. Thick, White Vaginal Discharge
B. Urinary Frequency
C. Vulva Lesions
D. Malodorous Discharge - CORRECTANSWER D. Malodorous Discharge

Although trichomoniasis may be asymptomatic, women commonly experience characteristically yellowish-to-greenish, frothy, mucopurulent, copious, malodorous discharge. Inflammation of the vulva, vagina, or both may be present; and the woman may complain of irritation and pruritus. Dysuria and dyspareunia are often present.

A nurse is caring for a client who is at 14 weeks of gestation. At which of the following locations should the nurse place the doppler device when assessing the fetal heart rate?

A. Midline 2 to 3 cm (0.8 to 1.2 in) above the symphysis pubis
B. Left Upper Abdomen
C. Two fingerbreadths above the umbilicus
D. Lateral at the Xiphoid Process - CORRECTANSWER A. Midline 2 to 3 cm (0.8 to 1.2 in) above the symphysis pubis

Toward the end of the first trimester, before the uterus is an abdominal organ, the fetal heart tones (FHTs) can be heard with an ultrasound fetoscope or an ultrasound stethoscope (Fig. 8-8). To hear the FHTs, place the instrument in the midline just above the symphysis pubis and apply firm pressure. The woman and her family should be offered the opportunity to listen to the FHTs. The health status of the fetus is assessed at each visit for the remainder of the pregnancy.

A nurse is assessing a client who is at 27 weeks of gestation and has preeclampsia. Which of the following findings should the nurse report to the provider?

A. Urine protein concentration 200 mg/24 hr.
B. Creatinine 0.8 mg/ dL
C. Hemoglobin 14.8 g/ dL
D. Platelet Count 60,000/ mm3 - CORRECTANSWER D. Platelet Count 60,000/ mm3

Platelets < 100,000/mm3 (60,000/mm3) is below the expected reference range, which can indicate DIC. The nurse should report this result to the provider. In a 24-hour specimen proteinuria is defined as a concentration at or > 300 mg/24 hours.

A nurse is teaching about clomiphene citrate to a client who is experiencing infertility. Which of the following adverse effect should the nurse include?

A. Tinnitus
B. Urinary Frequency
C. Breast Tenderness
D. Chills - CORRECTANSWER C. Breast Tenderness

The adverse effects of clomiphene citrate are stomach upset, bloating, abdominal/pelvic fullness, flushing ("hot flashes"), breast tenderness, headache, or dizziness may occur. If any of these effects last or get worse, tell your doctor or pharmacist promptly.

A nurse is assessing a newborn upon admission to the nursery. Which of the following should the nurse expect?

A. Bulging Fontanels
B. Nasal Flaring
C. Length from head to heel of 40 cm (15.7 in)
D. Chest circumference 2 cm (0.8 in) smaller than the head circumference - CORRECTANSWER D. Chest circumference 2 cm (0.8 in) smaller than the head circumference

Measure at nipple line 2-3 cm (0.8-1.2 in) less than head circumference; average 30-33 cm (11.8-13 in) ≤ 30 cm.

A nurse is planning care for a newborn who has neonatal abstinence syndrome. Which of the following interventions should the nurse include in the plan of care?

A. Increase the newborn's visual stimulation
B. Weigh the newborn every other day
C. Discourage parental interaction until after a social evaluation
D. Swaddle the newborn in a flexed position - CORRECTANSWER D. Swaddle the newborn in a flexed position

Swaddling in a flexed position with hands midline against chest and legs loosely swaddled in lumbar flexion to decrease sensory stimulation. Minimize environmental and physical stimulation low lighting and noise level do not use TV or mobiles. Avoidance of abrupt changes in infant's

environment handle gently and close to the body to increase sense of security.

A nurse is caring for a newborn who is 6 hrs. old and has a bedside glucometer reading of 65 mg/dL. The newborn's mother has type 2 diabetes mellitus. Which of the following actions should the nurse take?

A. Obtain a blood sample for a serum glucose level
B. Feed the newborn immediately
C. Administer 50 mL of dextrose solution IV
D. Reassess the blood glucose level prior to the next feeding. - CORRECTANSWER D. Reassess the blood glucose level prior to the next feeding.

When babies are just 1 hour to 2 hours old, the normal level is just under 2 mmol/L (36 mg/dL), but it will rise to adult levels (over 3 mmol/L or 54 mg/dL) within two to three days. In babies who need treatment for low blood glucose or are at risk for low blood glucose, a level over 2.5 mmol/L (45 mg/dL) is preferred.

A nurse is providing teaching to a client about exercise safety during pregnancy. Which of the following statements by the client indicates an understanding of the teaching? (Select all that apply).

A. "I will limit my time in the hot tub to 30 minutes after exercise."
B. "I should consume three 8-ounce glasses of water after I exercise."
C. "I will check my heart rate every 15 minutes during exercise sessions."
D. "I should limit exercise sessions to 30 minutes when the weather is humid."
E. "I should rest by lying on my side for 10 minutes following exercise." - CORRECTANSWER B. "I should consume three 8-ounce glasses of water after I exercise."

C. "I will check my heart rate every 15 minutes during exercise sessions."

E. "I should rest by lying on my side for 10 minutes following exercise."

Stay hydrated. Drink two or three 8-oz glasses of water after you exercise to replace the body fluids lost through perspiration. While exercising, drink water whenever you feel the need. Take your pulse every 10 to 15 minutes

while you are exercising. If it is more than 140 beats/min, slow down until it returns to a maximum of 90 beats/min. Rest for 10 minutes after exercising, lying on your side. As the uterus grows, it puts pressure on a major vein in your abdomen, which carries blood to your heart. Lying on your side removes the pressure and promotes return circulation from your extremities and muscles to your heart, thereby increasing blood flow to your placenta and fetus.

A charge nurse is teaching a group of staff nurses about fetal monitoring during labor. Which of the following findings should the charge nurse instruct the staff members to report to the provider?

A. Contraction durations of 95 to 100 seconds
B. Contraction frequency of 2 to 3 min apart
C. Absent early deceleration of fetal heart rate
D. Fetal heart rate is 140/min - CORRECTANSWER A. Contraction durations of 95 to 100 seconds

For a normal uterine activity during labor contraction duration remains fairly stable throughout first and second stages, ranging from 45-80 seconds, not generally exceeding 90 seconds.

A nurse in a woman's health clinic is obtaining a health history from a client. Which of the following findings should the nurse identify as increasing the client's risk for developing pelvic inflammatory disease (PID)?

A. Recurrent Cystitis
B. Frequent Alcohol Use
C. Use of Oral Contraceptives
D. Chlamydia Infection - CORRECTANSWER D. Chlamydia Infection

Pelvic inflammatory disease is an infection of a woman's reproductive organs. It is a complication often caused by some STDs, like chlamydia and gonorrhea. Other infections that are not sexually transmitted can also cause PID.

A nurse is teaching a prenatal class about immunizations that newborns receive following birth. Which of the following immunizations should the nurse include in the teaching?

A. Hepatitis B
B. Rotavirus
C. Pneumococcal
D. Varicella - CORRECTANSWER A. Hepatitis B

Hepatitis B immunization is recommended at birth, 1 to 2 months, and between 6 to 18 months. It is injected intramuscularly soon after birth. For newborns born to hepatitis- infected mothers, hepatitis B immune globin (HBIG) also should be administered within 12 hrs. of birth. The vastus lateralis is the preferred site of intramuscular injections in newborns, and no more than 0.5 mL should be administered in one injection. Shortly after birth, your baby should receive the first dose of the vaccine to help protect against the following disease: Hepatitis B and 1-month later RV, DTap, Hib, PCV13, & IPV.

16. A nurse is providing nutritional guidance to a client who is pregnant and follows a vegan diet. The client asks the nurse which foods she should eat to ensure adequate calcium intake. The nurse should instruct the client that which of the following foods has the highest amount of calcium?

A. 1⁄2 cup cubed avocado
B. 1 large banana
C. 1 medium potato
D. 1 cup cooked broccoli - CORRECTANSWER D. 1 cup cooked broccoli

1⁄2 cup cubed avocado contains 9 mg of calcium. 1 large banana contains 7 mg of calcium. 1 medium potato 26 mg of calcium. 1 cup cooked broccoli contains 180 mg of calcium.

A nurse in a provider's office is assessing a client at her first antepartum visit. The client states that the first day of her last menstrual period was March 8. Use Nagele's rule to calculate the estimated date of delivery. (Use the MMDD format with four numerals and no spaces or punctuation.) - CORRECTANSWER March 8 - 3 months = December 8 + 7 = Dec. 13 because of Feb. having 29 days.

A nurse is caring for a client who is in the second stage of labor. Which of the following manifestations should the nurse expect?

A. The client expels the placenta.
B. The client experiences gradual dilation of the cervix
C. The client begins to have regular contractions.
D. The client delivers the newborn. - CORRECTANSWER D. The client delivers the newborn.

The second stage of labor lasts from the time the cervix is fully dilated to the birth of the fetus.

A nurse is assessing a client who is at 37 weeks (about 8 and a half months) of gestation. Which of the following statement by the client requires immediate intervention by the nurse?

A. "It burns when I urinate."
B. "My feet are really swollen today."
C. "I didn't have lunch today, but I have breakfasted this morning."
D. "I have been seeing spot this morning." - CORRECTANSWER A. "It burns when I urinate."

During pregnancy, you are more susceptible to urinary tract infections. Most commonly, such infections are confined to the bladder, when they are known as cystitis. Symptoms of cystitis include a frequent, urgent need to urinate and a painful burning sensation when passing urine; there may be some blood in your urine.

A nurse is providing discharge teaching to a new parent about car seat safety. Which of the following statements by the parent indicates an understanding of the teaching?

A. "I should position my baby's car seat at a 45-degree angle in the car."
B. "I should place the car seat rear facing until my baby is 12 months old."
C. "I should place the harness snugly in a slot above my baby's shoulders."
D. "I should position the retainer clip at the top of my baby's abdomen." - CORRECTANSWER A. "I should position my baby's car seat at a 45-degree angle in the car."

Set the seat at a 45-degree angle. Your baby's head should rest at least 2 inches below the top of the car seat.

A nurse is developing an educational program about hemolytic diseases in newborns for a group of newly licensed nurses. Which of the following genetic information should the nurse include in the program as a cause of hemolytic disease?

A. The mother is Rh positive, and the father is Rh negative.
B. The mother is Rh negative, and the father is Rh positive.
C. The mother and the father are both Rh positive.
D. The mother and the father are both Rh negative. - CORRECTANSWER
B. The mother is Rh negative, and the father is Rh positive.

Hemolytic Diseases in Newborns (HDN) most frequently occurs when a Rh-negative mother has a baby with a Rh-positive father. When the baby's Rh factor is positive, like the father's, problems can develop if the baby's red blood cells cross to the Rh-negative mother. This usually happens at delivery when the placenta detaches.

A nurse on an antepartum unit is reviewing the medical records for four clients. Which of the following clients should the nurse assess first?

A. A client who has diabetes mellitus and an HbA1c of 5.8%
B. A client who has preeclampsia and a creatinine level of 1.1 mg/ dL
C. A client who has hyperemesis gravidarum and a sodium level of 110 mEq/L
D. A client who has placenta previa and a hematocrit of 36% - CORRECTANSWER C. A client who has hyperemesis gravidarum and a sodium level of 110 mEq/L

As a consequence of this physiological adaptation, normal pregnancy is associated with reduction in serum sodium of 3-6 mmol/L and reduction in serum osmolality of 10 mOsm/kg. Hyponatremia is diagnosed if serum sodium <135 mmol/L in non-pregnant individuals, but <130 mmol/L in pregnant women.

A nurse is assessing a newborn immediately following a vaginal birth. For which of the following findings should the nurse intervene?

A. Molding
B. Vernix Caseosa
C. Acrocyanosis

D. Sternal retractions - CORRECTANSWER D. Sternal retractions

Sternal retraction is a common clinical sign of respiratory distress in premature infants. Frontal chest radiographs show increased, ill-defined central radiolucency over the lower chest which correlates well with a curvilinear indentation seen on lateral views.

A nurse on the postpartum unit is caring for four clients. For which of the following clients should the nurse notify the provider?

A. A client who has a urinary output of 300 ml in 8 hr.
B. A client who reports abdominal cramping during breastfeeding
C. A client who is receiving magnesium sulfate and has absent deep tendon reflexes.
D. A client who reports lochia rubra requiring changing perineal pads every 3 hr. - CORRECTANSWER C. A client who is receiving magnesium sulfate and has absent deep tendon reflexes.

Symptoms of magnesium sulfate toxicity are seen with the following maternal serum concentrations: loss of deep tendon reflexes (9.6-12 mg/dL) (> 7 mEq/L), respiratory depression (12-18 mg/dL) (> 10 mEq/L), and cardiac arrest (24-30mg/dL) (> 25mEq/L).

A nurse is caring for a client who has active genital herpes simplex virus type 2. Which of the following medications should the nurse plan to administer?

A. Metronidazole
B. Penicillin
C. Acyclovir
D. Gentamicin - CORRECTANSWER C. Acyclovir

Acyclovir is used to treat infections caused by certain types of viruses. It treats cold sores around the mouth (caused by herpes simplex), shingles (caused by herpes zoster), and chickenpox. This medication is also used to treat outbreaks of genital herpes.

A nurse is caring for a client following an amniocentesis. The nurse should observe the client for which of the following complications?